APPENDICES

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Appendix A

Specifications for the Annual Rule 9-03 Data Filings

Appendix A is designed to assist Managed Care Organizations (MCOs) in preparing the annual March 31st and July 15th data filings required under Vermont Rule H-2003-09 ("Rule 9-03"). This appendix contains instructions for these two filings, as well as copies of forms and checklists designed to assist MCOs in assuring that all filing requirements are met.

As specified in Section 6.6(B), each MCO must file a copy of its quality improvement work plan with the Department by March 31st. The contents of the quality improvement work plan, as specified in Section 6.3(C), should include:

- "a written description of clinical and administrative quality improvement activities, including:
  - improvement goals and attendant measures,
  - project timelines,
  - accountable persons,
  - data collection activities and
  - how the activities meet objectives of the quality management program.

- the quality improvement goals agreed upon with the Department (or, at the discretion of the Department, selected by the managed care organization) and reported to the Department under Section 6.4(B)."

In addition, MCOs are also required to submit joint quality improvement goals as outlined in 6.3(D).

Reporting requirements for July 15th are specified in Section 6.6(B)(1) through (15) of Rule H-2009-03. These reporting requirements are explained in the remainder of Appendix A and are organized by type and source of data, i.e., HEDIS®, CAHPS®, and Rule 9-03-specific measurement requirements. Data submission tables developed by the Department for use by the MCOs are available as Excel spreadsheets.

Two checklists are also available at the end of Appendix A to further assist MCOs in preparing the July 15th data filing – one for Managed Mental Health Care Organizations and one for Managed Non-Mental Health Care Organizations.

A. HEDIS® Data Filing

HEDIS data submissions are required to meet the filing requirements specified in the following sections of Rule H-2009-03:

- 6.6(B)2
- 6.6(B)3
- 6.6(B)5
- 6.6(B)9
- 6.6(B)13

The Department's filing requirements are updated annually and track with the changes published in the most current NCQA HEDIS® Volume 2: Technical Specifications. The Department's requirements also reflect NCQA's annual rotation of reported measures. NCQA typically finalizes HEDIS® measures in October of each year. MCOs must submit HEDIS® data for their Vermont members only.

HEDIS® data may be filed using either the tables included in Appendix A or the NCQA IDSS report (exported into Excel), so long as the measures are based on Vermont member data only and include all required information. HEDIS RRU® measures must be reported in an XML format.

As of 2010, Managed Mental Health Care Organizations are required to submit only the following HEDIS® measure:

- Mental Health Utilization - % of members receiving any services, inpatient, intensive outpatient or partial hospitalization, and outpatient or ED services

All MCOs must provide verification that NCQA specifications were followed by submitting one of the following:

- HEDIS Compliance Audit;
- attestation from vendor, or
- vendor certification from NCQA.

The table on the following page lists the HEDIS® measures required for the next July 15 data filing. This table may be used as a checklist to assist in preparing an MCO's filing. The listing of required HEDIS® measures is repeated within the checklist at the end of this appendix. A copy of the checklist **must be submitted,** identifying each submitted data item, as part of the MCO's July data filing.

HEDIS® Measures for July 15, 2013
Effectiveness of Care Measures:
Table AIM 1/2: Immunizations for Adolescents
Table HPV 1/2: Human Papillomavirus Vaccine for Female Adults
Table BCS-1/2/3: Breast Cancer Screening
Table CCS-1/2: Cervical Cancer Screening
Table CHL-1/2: Chlamydia Screening in Women
Table CWP-1/2: Appropriate Testing for Children with Pharyngitis
Table URI-1/2: Appropriate Treatment for Children with Upper Respiratory Infection
Table AAB-1/2: Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
Table SPR-1/2/3: Use of Spirometry Testing in the Assessment of and Diagnosis of COPD
Table PCE-1/2/3: Pharmacotherapy Management of COPD Exacerbation
Table ASM-1/2/3: Use of Appropriate Medications for People with Asthma
Table MMA-1/2: Medication Management for People with Asthma
Table AMR – 1/2: Asthma Medication Ration
Table CBP: Controlling High Blood Pressure:
Table BPH-1/2/3: Persistence of Beta-Blocker Treatment after a Heart Attack
Table ART-1/2/3: Disease Modifying Anti-Rheumatic Drug Therapy for RA
Table LBP-1/2: Use of Imaging Studies for Low Back Pain
Table AMM-1/2/3: Antidepressant Medication Management
Table ADD-1/2: Follow-up Care for Children Prescribed ADHD Medication
Table FUH-1/2/3: Follow-up After Hospitalization for Mental Illness
Table MPM-1/2/3: Annual Monitoring for Patients on Persistent Medications
Aspirin Use and Discussion (ASP) (2-year rolling average--CAHPS)
Medical Assistance with Smoking and Tobacco Use Cessation (2-year rolling average--CAHPS)
Flu Shots for Adults Ages 50-64 (2-year rolling average--CAHPS)
Access/Availability of Care:
Table AAP-1/2/3: Adults' Access to Preventive/Ambulatory Health Services
Table CAP-1/2: Children's and Adolescents' Access to Primary Care Practitioners
Table IET-1/2/3: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
Table: PPC -1/2: Prenatal and Postpartum Care
Table CAT: Call Answer Timeliness
Use of Services:
Table W15-1/2/3: Well-Child Visits in the First 15 Months of Life
Table W34-1/2: Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
Table AWC-1/2: Adolescent Well-Care Visits
Table FSP-1&2: Frequency of Selected Procedures
Table AMB-2/3: Ambulatory Care
Table IPU-2/3: Inpatient Utilization General Hospital/Acute Care
Table IAD-1/2/3: Identification of Alcohol and Other Drug Services
Table MPT-1/2/3: Mental Health Utilization
Table ABX-1/2/3: Antibiotic Utilization
Table PCR-2/3 Plan All-Cause Readmissions
Relative Resource Use[1]:
Relative Resource Use for People with Diabetes (RDI)
Relative Resource Use for People with Asthma (RAS)
Relative Resource Use for People with Cardiovascular Conditions (RCA)
Relative Resource Use for People with Uncomplicated Hypertension (RHY)
Relative Resource Use for People with COPD (RCO)
Health Plan Descriptive Information:
Table ENP-2: Member Months of Enrollment by Age and Sex (Specify Product)

[1] For 2011 NCQA has changed the method for reporting Relative Resource Measures and requires the submission of XML data through the IDSS and no longer provides a visual presentation of the data. As such the Department cannot provide Excel tables for this submission. MCOs should provide RRU data in XML format to NCQA.

B. CAHPS® Data Filing

CAHPS® data submissions are required to meet the filing requirements specified in Section 6.6(B)11 of Rule H-2009-03:

All Managed Non-Mental Health Care Organizations must file the results of the CAHPS® Health Plan Survey, 5.0H Adult Version and report survey results for Vermont members only.

The CAHPS® survey must have been administered during the year in which it is submitted to the Department as part of the annual data filing requirements. The survey must be administered by an NCQA-certified vendor according to the most current NCQA CAHPS® survey administration and reporting protocols. Each MCO must include with its filings any one of the following three documents as evidence that this requirement has been met:

- a document from its NCQA-certified vendor attesting that in administering the surveys it followed NCQA specifications for sample selection, survey administration and data analysis;
- a certificate from NCQA certifying the vendor to be an NCQA-approved vendor, or
- a copy of the NCQA compliance audit.

MCOs may submit their results using tables included in this appendix or using NCQA banner tables. If banner tables are used, the submission must include each of the data items specified in the tables for each of the required questions.

The Department has provided the following four tables to assist MCOs in reporting CAHPS® results:

- CAHPS® Table 1: Demographics
- CAHPS® Table 2: Overall Ratings
- CAHPS® Table 3: Composite Table
- CAHPS® Table 4: Care Management Questions Table

These four tables are available as Excel spreadsheets.

C. Utilization Review Decisions Data Filing

Utilization review data submissions are required to meet the filing requirements specified in Section 6.6(B)8 of Rule 9-03.

UR data shall be submitted for dates covering the prior calendar year; that is, for a July 2013 submission, UR data must cover calendar year 2012.

The following UR categories provide the decision timeframes within which review decisions must be made to be in compliance with Rule 9-03.

UR Requests Categories	Rule 9-03 Timeframe
Concurrent Review	< 1 day
Urgent Pre-service Review	≤ 72 hours
Non-Urgent Pre-Service Review	≤ 15 days
Post Service Review	≤ 30 days

Reporting must be done in terms of calendar days.

In calculating UR timeframes, MCOs should consider the following clarifications:

1. **Pre-service urgent reviews**
   Section 3.2(D) allows the MCO a total of 72 hours to make a decision. If the MCO gives the member/provider additional time to supply additional requested information, the 72-hour countdown stops while the MCO waits for the member/provider to supply the requested information. Therefore, if a member is notified at hour 24 that additional information is needed, 48 hours remain of the 72-hour time period. When the MCO receives the additional information, the clock starts up again, giving the MCO 48 hours to render a decision.

2. **Pre-service non-urgent reviews**
   Section 3.2(E) allows the MCO a total of 15 days to render a decision under ordinary circumstances and 30 days if the MCO is facing circumstances beyond its control, including needing additional information from the member/provider. The section also provides the member/provider with at least 45 days to provide the additional needed information. The decision time clock stops as soon as the MCO requests additional information from the member or provider. The clock will commence where it left off as soon as the MCO receives the additional information. Therefore, if an MCO tells a member on day five that additional information is needed, once the additional information is received, the MCO will have 25 days (10 days from the initial timeframe and a 15 day extension) to render a decision.

3. **Post-service reviews**
   Section 3.2(F) allows the MCO a total of 30 days to render a decision under ordinary circumstances and 45 days if the MCO is facing circumstances beyond its control. As in Section 3.2(E), this section also requires MCOs to give members/providers at least 45 days to provide additional needed information. The decision time clock must stop at the time the member is notified of the need for additional information and commences as soon as the information is received. For example, if an MCO tells a member on day 15 that additional information is needed, the MCO will have 30 days (15 days from the initial timeframe and a 15 day extension) to render a decision once the requested information is received.

4. Sampling options

MCOs may report any or all of the four UR measures based on a randomly drawn sample or on the entire population of reviews. If using a sample, the sample size must be at least 60 denials within the category being measured. If during the reporting year the MCO had fewer than 60 denials within the category being measured, the MCO must report on the entire population of denials, and then randomly sample from approvals within the category being measured until the total number of reported reviews equals 60.

Sampled reviews should include reviews conducted for both inpatient and outpatient services. The precise sampling methodology is left to the MCO's discretion providing that it results in the defined random sample as described above.

D. Grievance Review Data Filing

Grievance review data submissions are required to meet the filing requirements specified in Section 6.6(B)7 of Rule 9-03.

Beginning July 2011, grievance data shall be reported for the prior calendar year (January 1 – December 31).

Grievance tables and registries

To assist in the reporting of grievances the Department has developed the following three tables:

Table 2: Grievance Frequency and Outcome
Table 3: Grievance Resolution Process (days to make a decision from the date on which the grievance was received)
Table 4: Number and Percent of Grievances per Member

The types and levels of grievances that are to be reported are specified in Tables 2 and 3. There is no differentiation between physical health and mental health/substance abuse grievances for reporting purposes when the grievances are unrelated to an adverse benefit determination. Pharmacy grievances must be included in grievance reporting.

In addition to submitting the required grievance tables, MCOs are also required to submit grievance registers that contain the following information:

- unique identifying number;
- general description of grievance;
- date grievance received by MCO;
- dates of review and hearing;
- whether grievance was resolved at first level or required second level review;
- date all necessary information was received in event of extension, and
- grievance resolution & date of resolution.

Examples of Grievances

The following scenarios provide examples of the application of the definitions of grievance stated above. The scenarios are presented in no particular order.

	GRIEVANCE? YES OR NO	SCENARIO	REASON/GRIEVANCE TYPE
1	Yes	A member calls to request reconsideration of a denial of service because no PA was obtained.	Yes, because member is requesting reconsideration of a denial. ***(Grievance concerning service denials or coverage)***
2	No	A member calls to ask why services coverage was denied and learns that PA was required. Member accepts explanation.	Member did not request further recourse.
3	Yes	A member calls about a claim denial issue related to service coverage, and requests that the claim be covered.	Yes, further recourse is requested. ***(Grievance concerning service denials or coverage)***
4	Yes	A member calls to make a request for reconsideration of a decision to approve only a partial coverage of services requested. (Member does not know the reason for denial).	Yes, if MCO accepts oral grievances. Member requests plan recourse about a denial. ***(Grievance concerning service denials or coverage)***
5	No	A member calls to inquire why there was a claims payment denial and learns it was due to use of an unauthorized out-of-network provider. Member understands.	No recourse sought.
6	Yes	A member calls about a claim denial issue related to an error on the claim and requests that it be fixed. The MCO is unable to resolve the error during the call. In the same scenario, if the issue is resolved on the phone, it is not a grievance because no further recourse is sought after the initial call.	Yes, recourse sought. ***(Grievance Unrelated to an Adverse Benefit Determination: plan administrative performance)***
7	No	During a follow-up call about a claim denial issue, the MCO explains that the claim was paid erroneously due to MCO error, and the member expresses satisfaction with the result.	Member requests no further action.
8	Yes	During a follow-up call two months later when the MCO explains that the claim was paid erroneously due to MCO error, the member expresses dissatisfaction with how MCO handled this issue and how long it took to do so and wants recourse, e.g., member requests that his unhappiness be noted by the MCO and MCO staff manager be notified.	Yes, member requests further recourse. Date of receipt of grievance is date of this follow-up call to member. Time between initial member contact and resolution call is immaterial. Only the member's expression of dissatisfaction is material. ***(Grievance unrelated to an adverse benefit determination: plan administrative performance)***
9	No	Member calls to find out if specific services are covered, learns they are not. Member is not happy to hear this, but accepts the explanation.	Member did not ask for any further recourse.
10	Yes	Member calls to find out if specific services are covered, learns they are not. Member is not happy to hear this, and asks to pursue the MCO making an exception.	Yes, member seeks further recourse from the MCO. ***(Grievance concerning service denials or coverage)***
11	Yes	Member sends a letter expressing dissatisfaction that does not necessarily include the words "grievance" or "appeal."	Dissatisfaction expressed in writing. ***(Type of grievance will depend on letter content)***
12	No	Member calls CEO to express dissatisfaction, and issue is resolved between member and CEO (this could include CEO transferring call to member services).	CEO resolves or transfers call to member services where grievance calls are logged. Member services will handle it and will log it as a grievance if content warrants.
13	Yes	Member calls to express dissatisfaction about physician balance billing, but does not necessarily use the words, "grievance," "complaint" or "appeal. The member wants the MCO to contact the physician.	Yes, because member is seeking recourse. ***(Grievance unrelated to an adverse benefit determination: grievance about provider performance)***
14	Yes	Member calls to complain that member ID card has not arrived in the mail and wants to receive it.	Yes, member is seeking recourse. ***(Grievance unrelated to an adverse benefit***

	GRIEVANCE? YES OR NO	SCENARIO	REASON/GRIEVANCE TYPE
			determination: grievance about plan administration)
15	No	MCO's sales rep is at a health fair and talks to a current member who says that she is thinking of switching to a new MCO because of problems around physician billing.	Member not seeking recourse from sales rep.
16	Yes	Member calls to complain about a provider's rude office staff. Member insists that the MCO registers the complaint.	Yes, member is seeking recourse. ***(Grievance unrelated to an adverse benefit determination: grievance about provider performance)***
17	Yes	Member writes to express anger at how long it took the MCO to address a concern about a claim error that resulted in an inappropriate denial.	Yes. ***(Grievance unrelated to an adverse benefit determination: grievance about plan performance)***
18	Yes	Member writes to request a reconsideration of a denial of a covered service she received out of network.	Yes. ***(Grievance about a service denial not requiring expedited review)***
19	Yes	Member writes to tell the MCO about how unhappy she is with the treatment she is receiving from her PCP and his office staff.	Yes. ***(Grievance unrelated to an adverse benefit determination: grievance about provider performance)***
20	Yes	Member writes to complain that there are too few choices of a particular specialty type provider in her geographic area.	Yes. ***(Grievance unrelated to an adverse benefit determination: grievance about access)***
21	Yes	Member calls to request an expedited review of a service denial.	Yes, oral expression of dissatisfaction is request for expedited review. ***(Grievance about a service denial requiring expedited review)***

E. Annual Filing of Provider Satisfaction Survey Data

Provider satisfaction survey data submissions are required to meet the filing requirements specified in Section 6.6(B)11 of Rule 9-03.

All MCOs must submit the results of an annual survey of network providers. Rule 9-03 requires that MCOs use a standardized state-approved survey instrument. The Department has approved and provided a core set of standard questions for provider satisfaction surveys. MCOs are expected to include at least this core set of standardized questions in their provider satisfaction surveys.

MCOs must also summarize any corrective actions taken based on the MCO's prior year provider satisfaction survey.

The provider satisfaction survey questions should be scored on a five point scale using the following responses:

- Strongly Agree
- Agree
- Neither Agree or Disagree
- Disagree
- Strongly Disagree

The Department-approved provider survey questions are:

1. Overall, I am satisfied with [MCO].
2. I would recommend [MCO] to other practitioners and to my patients.
3. [MCO's] staff is responsive when I need assistance.
4. [MCO's] quality of communications, such as care management tools, policy bulletins and manuals, is adequate.
5. [MCO] provides adequate support to patients with chronic conditions, or other serious illness.
6. [MCO's] prescription drug formulary is adequate.*
7. The amount of time spent obtaining [MCO] pre-approval for select prescription drugs is appropriate.*
8. The amount of time spent obtaining [MCO] pre-approval for services (other than prescription drugs) for my patients is appropriate.*
9. I have adequate access to [MCO's] Vermont utilization management department (e.g., when coverage for a service has been denied).
10. [MCO's] reimbursement levels are adequate.
11. [MCO's] claims payments are timely.
12. [MCO's] claims processing is accurate.
13. There are an adequate number and breadth of practitioners in [MCO's] network when I need to refer patients for other services.

* This question is not applicable to managed mental health care organizations. Managed mental health care organizations also do not need to include "(other than prescription drugs)" in Question #8 in their surveys.

F. Access: Travel Time Data Filing

Access data submissions, measured in terms of travel times to provider offices or facilities, are required to meet the filing requirements specified in Section 6.6(B)1 of Rule 9-03.

The travel time standards, detailed in Section 5.1(A) of Rule 9-03 are as follows:

Provider Type	Travel Time Standard
Primary Care Provider	30 minutes
Mental health/Substance Abuse (routine)	30 minutes
Outpatient specialty care	60 minutes
Intensive outpatient, partial hospitalization, residential or inpatient MH/SA services	60 minutes
Laboratory	60 minutes
Pharmacy	60 minutes
General optometry	60 minutes
Inpatient services	60 minutes
Imaging	60 minutes
Inpatient medical rehabilitation services	60 minutes
Kidney transplantation	90 minutes
Major trauma treatment	90 minutes
Neonatal intensive care	90 minutes
Tertiary-level cardiac services	90 minutes

The report shall include data on travel in terms of minutes, not mileage. When calculating travel time, the following assumptions regarding travel speed must be used: in urban areas – 25 mph; in suburban areas – 40 mph; in rural areas – 50 mph. These are the default values used by GeoAccess software to calculate travel times.

All geographic access reports for MCOs must be reported by county and at an aggregate state level. MCOs should not submit reports by town or zip code.

MCO are required to submit access reports on the following provider types annually:

Access within 30 minutes:

- Adult PCPs
- Pediatric PCPs
- Outpatient mental health and substance abuse services

MCOs should report any member up to their 20th birthday as a "child" for reporting requirements for adult and pediatric PCPs.

Access within 60 minutes:

- Outpatient physician specialty care (specific specialties rotate annually – see checklist for annual filing requirements)
- Intensive outpatient, partial hospital, residential or inpatient mental health and substance abuse services

MCOs are required to submit access reports on the following provider types on a rotating basis. The specific provider types are listed in the annual checklist update:

Access within 60 minutes:

- Laboratory
- Pharmacy
- General Optometry
- Inpatient
- Imaging
- Inpatient Medical Rehabilitation Services

Access within 90 minutes:

- Kidney Transplantation
- Major Trauma Treatment
- Neonatal Intensive Care
- Tertiary-Level Cardiac Services, including procedures such as cardiac catheterization and cardiac surgery

With respect to measures relative to travel to primary care services, MCOs must follow these guidelines:

- The report must include only primary care practices with open panels (i.e., practices are accepting new patients).

- MCOs must run separate reports for adult primary care and pediatric primary care providers.

- Measurement of adult primary care access must include internists and family practitioners and may include OB/GYNs, but only if they are actively serving MCO members in the capacity of a primary care provider.

- Measurement of pediatric care access should include pediatricians and family practitioners.

- MCOs must report information on network composition any time between April 1st and June 30th of the year in which the report is being filed.

- Health centers and clinics are not to be considered providers as part of the geographic access report. Instead, all individual practitioners, regardless of work location (e.g., private office, group practice, clinic), are to be included in the report.

With respect to travel time to outpatient mental health and substance abuse services, MCOs must:

- Report access to mental health and substance abuse services separately and also separately by provider type (e.g. inpatient, intensive outpatient/partial hospitalization, and outpatient/emergency department). HEDIS® definitions are to be used for all terms.

- Report by professional credentials for outpatient mental health services. Include master's level trained psychologists with other master's level trained professionals, such as licensed clinical social workers. Exclude ED facilities from this portion of the analysis.

- When reporting travel time to outpatient/ED mental health services, MCOs operating special integrated programs to serve dually diagnosed patients may report the programs serving this population in both the mental health and the substance abuse categories. This is also the case for other provider organizations that include both substance abuse and mental health treatment specialists on their staffs.

G. Access: Waiting Time Data Filing

Access data submissions, measured in terms of waiting times for provider services, are required to meet the filing requirements specified in Section 6.6(B)1 of Rule 9-03.

The waiting time standards, delineated in Rule 9-03, Section 5.1(B), are as follows:

Service Type	Waiting Time Standard
Emergency services	Immediately
Urgent care	24 hours
Non-emergency, non-urgent care	2 weeks
Preventive care	90 days

With respect to appointment waiting time, MCOs may elect to:

- use MCO-defined data collection methods for assessing performance against Rule 9-03 appointment wait time requirements, or

- sample their membership rather than report information for their entire membership, provided that the MCO provides a written description of the sampling methodology when submitting its survey results.

MCOs are required to report on the following categories for physical health care services:

- Emergency care;

- Urgent care;

- Non-emergency, non-urgent care, and

- Preventive care and routine physical examinations.

MCOs are required to report on the following categories for mental health/substance abuse services:

- Emergency care;

- Urgent care, and

- Non-emergency, non-urgent care.

Waiting time for mental health and substance abuse services must be distinguished and reported separately from waiting time for physical health care.

H. Current and Terminated Providers Data Filing

Data submissions regarding provider-initiated and plan-initiated terminations are required to meet the filing requirements specified in Section 6.6(B)10 of Rule 9-03.

MCOs must list all provider-initiated and plan-initiated terminations between January 1st and December 31st of the measurement year, keeping in mind that:

- Providers should not be considered "terminated" if they have died, retired or relocated.
- MCOs must group terminated contracts by MCO-defined categories of "reasons for termination" such as "documented quality problem" or "unwillingness to adhere to MCO UR and referral policies."
- The precise reason for termination must be indicated.
- The type of provider must be specified.

I. Provider Directories

Submission of provider directories is required to meet the filing requirements specified in Section 6.6(B)10 of Rule 9-03.

Provider directories may be submitted in electronic copy or a link to a website may be provided.

J. Delegated Functions

MCOs are required to submit information regarding delegated functions. Requirements are specified within Section 6.6(B)15 of Rule 9-03.

MCOs that delegate functions to contracted providers must submit information in Table 5: List of Delegated Functions.

K. Coordination and Continuity of Care Indicators

Data submissions regarding coordination and continuity of care indicators are required to meet the filing requirements specified in Section 6.6(B)4.

MCOs should submit data for the HEDIS® measure Plan All-Cause Readmissions (Table PCR – 2/3) to meet this requirement. This measure is included in the checklist under HEDIS® measures Use of Services.

L. Blueprint for Health Data Filing

MCO are required to submit data on specific measures to assess provider adoption and MCO support for Blueprint for Health concepts to meet Section 6.6(B)6 requirement of Rule 9-03:

1. Percent of contracted primary care providers (PCPs) receiving enhanced payment to support medical home operation.
   - The numerator for this measure is the number of contracted PCPs receiving enhanced payment to support medical home operations. The denominator for this measure is the total number of contracted PCPs in the network. The time period for this measure is January 1 through December 31 of the calendar year of the reporting period. MCOs are required to report this information in Table 6.

2. Per member per month (PMPM) value of enhanced practice payments to support medical home operation.
   - MCOs should report the total PMPM value of the enhanced practice payments they are making to support medical home operations. Total PMPM value should be calculated as the total enhanced practice payments over the total member months. The time period for this measure is January 1 through December 31 of the calendar year of the reporting period. MCOs are required to report this figure in Table 7.

3. Names and the percentage of Vermont Hospital Service Areas where the MCO is making payments to support Community Health Teams in accordance with Vermont Blueprint-defined payment terms
   - MCOs should indicate the Vermont Hospital Service Areas (VSAs) to which they are making payments to support Community Health Teams in accordance with Vermont Blueprint-defined payment terms by putting a "Y" next to the relevant HSA. They should then calculate what percentage of all Vermont HSAs are receiving such payments. The time period for this measure is January 1 through December 31 of the calendar year of the reporting period. MCOs are required to report this in Table 8.

CHECKLIST FOR MANAGED NON-MENTAL HEALTH CARE ORGANIZATIONS RULE 9-03 JULY 15TH DATA FILING		
HEDIS®	**Effectiveness of Care Measures:** ___ Table AIM-1/2: Immunizations for Adolescents ___ Table HPV 1/2: Human Papillomavirus Vaccine for Female Adults ___ Table BCS-1/2/3: Breast Cancer Screening ___ Table CCS-1/2: Cervical Cancer Screening ___ Table CHL-1/2: Chlamydia Screening in Women ___ Table CWP-1/2: Appropriate Testing for Children with Pharyngitis ___ Table URI-1/2: Appropriate Treatment for Children with Upper Respiratory Infection ___ Table AAB-1/2: Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis ___ Table SPR-1/2/3: Use of Spirometry Testing in the Assessment of and Diagnosis of COPD ___ Table PCE-1/2/3: Pharmacotherapy Management of COPD Exacerbation ___ Table ASM-1/2/3: Use of Appropriate Medications for People with Asthma ___ Table AMR – 1/2: Asthma Medication Ratio ___ Table MMA - 1/2: Medication Management for People w/ Asthma ___ Table CHP: Controlling High Blood Pressure ___ Table BPH-1/2/3: Persistence of Beta-Blocker Treatment after a Heart Attack ___ Table ART-1/2/3: Disease Modifying Anti-Rheumatic Drug Therapy for RA ___ Table LBP-1/2: Use of Imaging Studies for Low Back Pain ___ Table AMM-1/2/3: Antidepressant Medication Management ___ Table ADD-1/2: Follow-up Care for Children Prescribed ADHD Medication ___ Table FUH-1/2/3: Follow-up After Hospitalization for Mental Illness ___ Table MPM-1/2/3: Annual Monitoring for Patients on Persistent Medications ___ Aspirin Use and Discussion (ASP) (2-year rolling average--CAHPS) ___ Medical Assistance with Smoking Cessation (2-year rolling average--CAHPS) ___ Flu Shots for Adults Ages 50-64 (2-year rolling average--CAHPS) **Access/Availability of Care:** ___ Table AAP-1/2/3: Adults' Access to Preventive/Ambulatory Health Services ___ Table CAP-1/2: Children's and Adolescents' Access to Primary Care Practitioners ___ Table IET-1/2/3: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment ___ Table PPC – 1/2: Prenatal and Postpartum Care ___ Table CAT: Call Answer Timeliness **Satisfaction with the Experience of Care:** ___ HEDIS/CAHPS 5.0H: Adult survey ___ Mental health/substance abuse member satisfaction survey required by Act 129	___ HEDIS Submission Tool ___ Verification that NCQA specifications were followed: ____ HEDIS Compliance Audit, or ____ Attestation from vendor, or ___ Vendor certification from NCQA

CHECKLIST FOR MANAGED NON-MENTAL HEALTH CARE ORGANIZATIONS RULE 9-03 JULY 15TH DATA FILING		
HEDIS®	**Use of Services:** ___ Table W15-1/2/3: Well-Child Visits in the First 15 Months of Life ____ Table W34-1/2: Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life ____ Table AWC-1/2: Adolescent Well-Care Visits ____ Table FSP-1&2: Frequency of Selected Procedures ____ Table AMB-2/3: Ambulatory Care ____ Table IPU-2/3: Inpatient Utilization General Hospital/Acute Care ____ Table IAD-1/2/3: Identification of Alcohol and Other Drug Services ____ Table MPT-1/2/3: Mental Health Utilization ____ Table ABX-1/2/3: Antibiotic Utilization ____ Table PCR – 2/3 Plan All-Cause Readmissions **Relative Resource Use[2]:** ___ Relative Resource Use for People with Diabetes (RDI) ___ Relative Resource Use for People with Asthma (RAS) ___ Relative Resource Use for People with Cardiovascular Conditions (RCA) ___ Relative Resource Use for People with Uncomplicated Hypertension (RHY) ___ Relative Resource Use for People with COPD (RCO) **Health Plan Descriptive Information:** ___ Table ENP-2: Member Months of Enrollment by Age and Sex (Specify Product)	

[2] For 2011 NCQA has changed the method for reporting Relative Resource Measures and requires the submission of XML data through the IDSS and no longer provides a visual presentation of the data. As such the Department cannot provide Excel tables for this submission. MCOs should provide RRU data in XML format.

CHECKLIST FOR MANAGED NON-MENTAL HEALTH CARE ORGANIZATIONS RULE 9-03 JULY 15TH DATA FILING		
CAHPS® 5.0H Surveys	Plans may submit either their CAHPS banner tables or the CAHPS survey submission templates provided by the Department, so long as all required information is provided. Please check in the box to the right which option is being used to meet the CAHPS data submission requirements.	_____ certification letter from vendor _____ survey response rate summary table (hard copy) _____ CAHPS banner tables, or _____ CAHPS survey submission (using Department templates)
Provider Directory		_____ Provider Directory (Hard copy or electronic)
UR Decisions	Please check the methodology used for generating the sample: ___ 60 prospective reviews, or ___ entire population of denials and then randomly sampled approvals until sample size equals 60 Verify (check) that this parameter is met: ___ reporting is in terms of calendar days UR data should be submitted for the previous 12-month period (January 1– December 31).	_____ Table 1: Time to make UR decisions from receipt of request
Access: Travel Time **Access to PCP**	Verify (check) that each parameter is met: ___ network composition is as of any time between April 1st and June 30th of year in which the report is being filed ___ travel time is reported in terms of minutes using Department-adopted assumptions regarding miles per hour ___ data is provided across entire Vermont service area Verify (check) that each parameter is met: _____ includes only panels open to new patients _____ adult PCP includes internists, family practitioners and OB/GYNs (if actively serving as PCP) _____ pediatric PCP includes pediatricians and family practitioners _____ child is defined as a member up until the 20th birthday for this purpose	_____ GeoAccess report for adult PCP within 30 minutes _____ GeoAccess report for pediatric PCP within 30 minutes
Access: Travel Time Access to outpatient MH and CD facilities	Verify (check) that each parameter is met: _____ access to MH and CD providers are reported separately	Two separate GeoAccess reports for each of the following (one representing the entire Vermont service area and one depicting access by county) **Outpatient/ED mental health by provider type within 30 minutes** **VT County** ____ ____psychiatrist ____ ____psychologist (doctoral level only) ____ ____master of social work and other master's level (including all master's level psychologists) ____ ____all outpatient MH providers (single aggregate report of all the above categories of MH provider types)

CHECKLIST FOR MANAGED NON-MENTAL HEALTH CARE ORGANIZATIONS RULE 9-03 JULY 15TH DATA FILING		
		____ ____all ambulatory CD providers (single aggregate report of all the above categories of CD provider types)
Access: Travel Time Access to specialty services		Separate GeoAccess reports for access to each of the following services: **Specialty service by provider type within 60 minutes** **VT County** ____ ____inpatient mental health, ____ ____inpatient chemical dependency, ____ ____intensive outpatient/partial hospitalization mental health providers ____ ___ intensive outpatient/partial hospitalization chemical dependency providers **Selected outpatient specialty care specified by the Department. For the July 2013 filing, submit access reports for the following outpatient specialties:** ____ ____ Chiropractors ____ ____ bariatric surgeons ____ ____ urologists **Specialty service by provider type within 90 minutes** **VT County** ____ ____neonatal intensive care,
Access: Waiting Time	Waiting time is assessed separately for combined mental health/substance abuse services. Please check the methodology used for assessing waiting times: _____ entire membership _____ sampled membership _____ if used a sample, verify that written description of sampling methodology was provided	Results of waiting time assessment for each of following services: (separate assessments should be provided for mental health/substance abuse and for physical health) **Phy. MH/SA** ____ ____ urgent care ____ ____ non-emergent, non-urgent care and follow-up ____ _NA_ preventive care (including routine physical exam)
Grievances	MCOs should note that there is no differentiation between physical health and mental health/substance abuse services for reporting purposes for grievances unrelated to an adverse benefit determination. Grievance data should be submitted for the previous 12-month period (January 1– December 31). Pharmacy grievances must be included in grievance reporting.	_____Table 2: Grievance frequency and outcome _____Table 3: Grievance resolution process - days to make a decision _____Table 4: Number and percent of grievances per member _____ Grievance Register Grievance register must contain:

CHECKLIST FOR MANAGED NON-MENTAL HEALTH CARE ORGANIZATIONS RULE 9-03 JULY 15TH DATA FILING		
		___ unique identifying number for each grievance ___ general description of grievance ___ date grievance received by MCO ___ dates of review and hearing ___ whether grievance was resolved at first level or required second level review ___ date all necessary information was received in event of extension ___ grievance resolution & date of resolution
Lists of Current and Terminated Providers		___ list of terminated providers[3] (by MCO action) and reason for termination
Annual Provider Satisfaction Survey		____ blank copy of provider satisfaction survey ____ results of provider satisfaction survey ____ summary of corrective actions taken based on prior year's provider satisfaction survey
Rule H-2009-03 Delegated Functions		____ Table 5: List of Delegated Functions & Entities (provide effective dates for any newly delegated functions over the past reporting period)
Coordination and Continuity of Care Indicators		_____ HEDIS® Table PCR – 2/3 Plan All-Cause Readmissions (Included in HEDIS® section)
Blueprint for Health	Data should be submitted for the previous 12-month period (January 1– December 31).	_____ Table 6: Percent of contracted PCPs receiving enhanced payment to support medical home operation _____ Table 7: PMPM value of enhanced practice payments to support medical home operation _____ Table 8: Names and the percentage of Vermont Hospital Service Areas where the MCO is making payments to support Community Health Teams in accordance with Vermont Blueprint-defined payment terms
Material Changes	MCOs are required to submit information regarding material changes to policies, procedures, member communications, provider contracts or any other documents required by this rule.	_____ Material changes submitted

[3] MCOs should only report on those providers whose contracts were terminated due to MCO action, and not those terminated due to retirement, death, those who choose to end contracts, or relocation outside of Vermont.

Checklist for MBHO

CHECKLIST FOR MANAGED MENTAL HEALTH CARE ORGANIZATION RULE 9-03 JULY 15TH DATA FILING		
HEDIS®	____ MH Utilization - % of members receiving any services, inpatient, intensive outpatient or partial hospitalization, and outpatient or ED services	____ HEDIS Submission Tool ____ Verification that NCQA specifications were followed: ____ HEDIS® Compliance Audit, or ____ Attestation from vendor, or ____ Vendor certification from NCQA
Act 129 Mental Health/Substance Abuse Member Satisfaction Survey	See separate Department instructions regarding compliance with Act 129 for instructions on completing the mental health/ substance abuse member satisfaction survey	_____ survey and survey results
Access: Travel Time	Verify (check) that the parameter is met: ____ access to MH and CD providers are reported separately	Two separate GeoAccess reports for each of the following (one representing the entire Vermont service area and one depicting access by county) : **Outpatient/ED mental health by provider type within 30 minutes, except as otherwise indicated:** **VT County** ____ ____ psychiatrist ____ ____ psychologist (doctoral level only) ____ ____ master social work and other masters level (including all masters level psychologists) ____ ____ all outpatient MH providers (single aggregate report of all the above categories of MH provider types) ____ ____ all ambulatory CD providers (single aggregate report of all the above categories of CD provider types) ____ ____ intensive outpatient/partial hospitalization mental health providers within 60 minutes ____ ____ intensive outpatient/partial hospitalization chemical dependency providers within 60 minutes
Access: Waiting Time	Waiting time is assessed separately for combined mental health/substance abuse services. Please check the methodology used for assessing waiting times: _____ entire membership _____ sampled membership _____ if used a sample, verify that written description of sampling methodology was provided	_____ results of waiting time assessment for the following service: _____ urgent care _____ non-emergent, non-urgent care and follow-up

CHECKLIST FOR MANAGED MENTAL HEALTH CARE ORGANIZATION RULE 9-03 JULY 15TH DATA FILING		
UR Decisions	Please check the methodology used for generating the sample: ___ 60 prospective reviews, or ___ entire population of denials and then randomly sampled approvals until sample size equals 60 Verify (check) that this parameter is met: ___ reporting is in terms of calendar days UR data should be submitted for the previous 12-month period (January 1– December 31).	_____ Table 1: Time to make UR decisions from receipt of request
Grievances	Please note that grievance data should be submitted for the previous 12-month period (January 1–December 31).	_____Table 2: Grievance frequency and outcome _____Table 3: Grievance resolution process - days to make a decision _____Table 4: Number and percent of grievances per member _____ Grievance Register Grievance register must contain: ___ unique identifying number for each grievance ___ general description of grievance ___ date grievance received by MCO ___ dates of review and hearing ___ whether grievance was resolved at first level or required second level review ___ date all necessary information was received in event of extension ___ grievance resolution & date of resolution
Lists of Current and Terminated Providers		_____ Provider directory (hard copy or electronic) _____ list of terminated providers[4] (by MCO action) and reason for termination
Annual Provider Satisfaction Survey		_____ blank copy of provider satisfaction survey _____ results of provider satisfaction survey _____ summary of corrective actions taken based on prior year's provider satisfaction survey
Rule H-2009-03 Delegated Functions		_____ Table 5: List of Delegated Functions & Entities (provide effective dates for any newly delegated functions over the past reporting period)
Material Changes	MBHOs are required to submit information regarding material changes to policies, procedures, member communications, provider contracts or any other documents required by this rule.	_____ Material changes submitted

[4] MCOs should only report on those providers whose contracts were terminated due to MCO action, and not those terminated due to retirement, death, those who choose to end contracts, or relocation outside of Vermont.

Appendix B

MCO Quality Improvement Goal Template
_____ Goal Year

MCO Name:

Goal:

Goal Objectives:
1.
2.
3.
4.

Baseline Data and Measurable Goal Results:

Measure	**Baseline Data** _____ (Time Period)	**Interim Data** _____ (Time Period)	**Target Goal (# or %)**

MCO Quality Improvement Goal Template
_____ Goal Year Reporting

Mid-Year Reporting

Goals and Measures of Progress for the 1st (mid-year) Simi-annual Goal Review Meeting:
(*measures should be quantifiable whenever feasible and appropriate.)*

1.

2.

3.

4.

Year-End Reporting

Measures of Progress and Goal Attainment for the 2nd (year-end) Semiannual Goal Review Meeting *(measures should be quantifiable whenever feasible and appropriate)*

1.

2.

3.

4.

5.

MCO Quality Improvement Goal Template
Example

MCO Name: ABC MCO

Goal: *Example:* Improve glycemic control among enrolled diabetic members and achieve a statistically significant improvement in the HbA1c control rate for diabetics.

Goal Objectives:

1. *Implement an on-line system for monitoring and self-management of diabetic members*
2. *Enroll 90% of high-risk diabetic members in the DM Program*
3. *Reduce voluntary turnover rate in DM Program to no more than 10*
4. *Implement a quality incentive program that rewards a) PCPs who have been able to achieve glycemic control for 60% of their patients, and b) individual members who achieve glycemic control*

Baseline Data and Measurable Goal Results:

Measure	Baseline Data _____ (Time Period)	Interim Data _____ (Time Period)	Target Goal (# or %)
HbA1c control	*40%*	*42%*	*60%*
High-risk diabetic enrollment in DM Program	*NA*	*60%*	*90%*
Diabetes DM turnover rate	*NA*	*20%*	*<or=10%*

MCO Quality Improvement Goal Template
Example

Mid-Year Reporting

Goals and Measures of Progress for the 1st (mid-year) Simi-annual Goal Review Meeting:
(*measures should be quantifiable whenever feasible and appropriate.)*

Examples:

1. *The on-line system for monitoring and self-management of diabetic members is in beta testing with a pre-selected group of diabetic members.*

2. *80% of high-risk diabetics are enrolled in the DM Program.*

3. *Year-to-date, the voluntary rate of membership termination in the DM Program equals 15%.*

4. *QI incentive program specifications have been developed and are undergoing testing with members and PCPs.*

5. *Measured changes in glycemic levels for participants in the DM Program indicate improvement when compared to the prior year scores for continuously enrolled members*

Year-End Reporting

Measures of Progress and Goal Attainment for the 2nd (year-end) Semiannual Goal Review Meeting
(measures should be quantifiable whenever feasible and appropriate)

Examples:

1. *The on-line monitoring and self-management system for diabetic members has been implemented and its availability has been communicated to members and providers through multiple modalities of communication.*

2. *90% of high-risk diabetics are enrolled in the DM Program.*

3. *The year-to-date DM program voluntary termination rate equals 10%.*

4. *The quality incentive program specifications have been completed and tested and are ready for January 1 implementation.*

5. *Measured changes in glycemic levels of DM Program participants indicate statistically significant improvement. Final goal measurement will be result from forthcoming HEDIS measurement and will be available in June.*

Appendix C

Section 6.3(G) Performance Improvement Measures

Section 6.3(G) of Rule 9-03 requires that each MCO demonstrate performance improvement with respect to several categories of measures developed by applicable national organizations with recognized expertise in quality measures. The Department has identified the following HEDIS® and CAHPS® measures as applicable to the requirements of this section of the rule. Improvement must be demonstrated on the basis of an individual measure, which can be either a composite or any of its subcomponents. Not all of these measures will be available for evaluation of improvement during every triennial review period due to annual measurement rotation or changes in measure specifications. The list that follows will be updated as new measures are introduced and older measures retired.

For a given triennial review, the Department will base its evaluation on the HEDIS® and CAHPS® data filings that coincide with the period of time that is the focus of the triennial review. Examples of potential measures are listed below.

HEDIS Access/Availability of Care and Use of Services Measures

- Adults' Access to Preventive/Ambulatory Care
- Children and Adolescents' Access to Ambulatory Care
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment Composite
    - Initiation of alcohol and other drug dependence treatment
    - Engagement of alcohol and other drug dependence treatment
- Timeliness of Prenatal Care
- Postpartum Care
- Call Answering Composite
    - Call Abandonment
    - Call Answer Timeliness
- Well-child Visits in the First 15 Months of Life
- Well-child Visits in the Third, Fourth, Fifth and Sixth Years of Life
- Adolescent Well Care Visits

6.3 (G) 1. Member service, satisfaction and experience of care

CAHPS® Member Satisfaction Measures

- Rate your overall health plan experience
- Getting Needed Care Composite
    - Ease with which to get an appointment with specialists
    - Easy to get the care, tests, or treatment you thought you needed
- Claims Processing Composite
    - Claims processing is timely
    - Claims are processed correctly
- Plan Information on Costs Composite
    - Able to find out how much to pay for a health care service or equipment
    - Able to find out how much to pay for prescription medications
- Health Plan Customer Service Composite
    - Written materials or internet provided the information you needed about how health plan works
    - Customer service gave information or help needed
    - How often did customer service staff treat you with courtesy/respect

- Health plan forms easy to fill out

6.3 (G) 2. Preventive care

HEDIS® Preventive Care Measures

- Adult BMI Screening
- Weight Assessment & Counseling for Nutrition and Physical Activity for Children & Adolescents - BMI Percentile
- Weight Assessment & Counseling for Nutrition and Physical Activity for Children & Adolescents – Counseling for Nutrition
- Weight Assessment & Counseling for Nutrition and Physical Activity for Children & Adolescents – Counseling for physical activity
- Childhood Immunization Status
- Immunizations for Adolescents
- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening Composite
  - Chlamydia screening 16-20
  - Chlamydia screening 21-24
- Colorectal Cancer Screening
- Flu Shot for Adults Ages 50-64
- Medical Assistance with Smoking and Tobacco Use Cessation

6.3 (G) 3. Acute illness care

HEDIS® Acute Illness Measures

- Care for Children Composite
  - Appropriate Testing for Children With Pharyngitis
  - Appropriate Treatment for Children With Upper Respiratory Infection
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Follow Up after Hospitalization for Mental Illness: 30 Days
- Follow Up after Hospitalization for Mental Illness: 7 Days
- Use of Imaging Studies for Lower Back Pain
- Antidepressant Medication Management Composite
  - Effective acute phase treatment
  - Effective continuation phase treatment

6.3 (G) 4. Chronic illness care

HEDIS® Chronic Illness Measures

- Caring for People with Asthma
- Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Screening
- Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Level <100
- Diabetic Composite
    - HbA1c testing
    - Diabetic eye exam
    - Good HbA1c control <8%
    - Poor HbA1c control >9%
    - LDL-C level <100
    - LDL-C screening
    - Monitoring blood pressure control <130/80
    - Monitoring blood pressure control <140/90
    - Monitoring for diabetic nephropathy
- Annual Monitoring for Patients on Persistent Medications Composite
    - Annual monitoring for patients on ACE inhibitors or ARB
    - Annual monitoring for patients on anticonvulsants
    - Annual monitoring for patients on diuretics
- Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
- Persistence of Beta-Blocker Treatment After a Heart Attack
- Use of Spirometry Testing in the Assessment of and Diagnosis of COPD

Appendix D

VERMONT REGULATORY REQUIREMENTS ADDENDUM

This Vermont Regulatory Requirements Addendum ("Addendum") is made part of the Provider Agreement ("Agreement") entered into between [MANAGED CARE ORGANIZATION NAME] and the health care professional or entity named in the Agreement ("Provider"). This Addendum applies to the covered services rendered to members in Vermont to the extent such covered services are subject to regulation under Vermont laws.

[MANAGED CARE ORGANIZATION NAME], and Provider each agree to be bound by the terms and conditions contained in this Addendum. In the event of a conflict or inconsistency between this Addendum and any term or condition contained in the Agreement, this Addendum shall control, except with regard to health benefit plans outside the scope of this Addendum.

1. **Member Hold Harmless.** Provider agrees that in no event, including nonpayment or insolvency of [MANAGED CARE ORGANIZATION NAME], or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a member or a person (other than [MANAGED CARE ORGANIZATION NAME]) acting on behalf of the member for services provided pursuant to the Agreement. This Agreement does not prohibit Provider from collecting coinsurance, deductibles or copayments, as specifically provided in the certificate of coverage, or fees for uncovered services delivered on a fee-for-service basis to members.
   This Agreement prohibits Provider from requesting payment from a member for any services that have been confirmed by independent external review obtained through the Department of Financial Regulation pursuant to Vermont law to be medically unnecessary, experimental, investigational or a medically inappropriate off-label use of a drug.
2. **Continuation of Covered Services Following Termination.** In the event of [MANAGED CARE ORGANIZATION NAME]'s insolvency or other cessation of operations, covered services to a member will continue to be provided through the period for which a premium has been paid to [MANAGED CARE ORGANIZATION NAME] on behalf of the member or until the member's discharge from an inpatient facility, whichever period is greater. Covered services to a member confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until the member's continued confinement in the facility is no longer medically necessary.
   In the event the Agreement is terminated without cause, or has not been renewed without cause, members receiving an ongoing course of treatment from Provider may continue to utilize Provider so long as Provider agrees to abide by [MANAGED CARE ORGANIZATION NAME]'s payment rates, quality of care standards and protocols, and to provide the necessary clinical information to [MANAGED CARE ORGANIZATION NAME], as follows: members with disabling or degenerative conditions shall be allowed to continue to see Provider for sixty (60) days from the date of termination or nonrenewal or until accepted by a provider contracted with [MANAGED CARE ORGANIZATION NAME], whichever is shorter, and women in their second or third trimester of pregnancy shall be allowed to continue to obtain care from Provider until the completion of postpartum care.
3. The provisions in Sections 1 and 2 shall be construed in favor of the member, shall survive the termination of the Agreement regardless of the reason for termination, including [MANAGED CARE ORGANIZATION NAME]'s insolvency, and shall supersede any oral or written contrary agreement between Provider and a member or a member's representative if the contrary agreement is inconsistent with the "Member Hold Harmless" and "Continuation of Covered Services Following Termination" provisions in Sections 1 and 2.

4. **Notice of Termination.** Either party terminating the Agreement without cause shall provide to the other party advance final written notice in the form and for the length of time as provided in the Agreement but in no case less than sixty (60) days before terminating the Agreement.
5. **Notice of Termination to Members.** [MANAGED CARE ORGANIZATION NAME] shall provide written notice of the termination of Provider at least six (6) weeks prior to the anticipated date of a termination without cause, or on, or if possible, before the date on which the Agreement is terminated by [MANAGED CARE ORGANIZATION NAME] or Provider for cause, to all members <who are patients of [IF PRIMARY CARE PROVIDER]> [OR] <who are seen on a regular basis by Provider [IF SPECIALTY PROVIDER]>. Within five (5) business days of the date Provider either gives or receives notice of termination, either for or without cause, Provider shall supply [MANAGED CARE ORGANIZATION NAME] with a list of his or her patients that are members of [MANAGED CARE ORGANIZATION NAME].
6. **No Transfer of [MANAGED CARE ORGANIZATION NAME]'s Liability.** Nothing in the Agreement shall be construed to contain any clause purporting to transfer to Provider, other than a medical group, by indemnification or otherwise, any liability relating to the activities, actions or omissions of [MANAGED CARE ORGANIZATION NAME].
7. **Disclosure of Contract Provisions.** Nothing in the Agreement shall be construed as prohibiting Provider from disclosing to members or potential members information about the Agreement or the members' health benefit plans that may affect their health or any decision regarding health.
8. **Freedom to Discuss Treatment Options.** Nothing in the Agreement shall be construed as prohibiting Provider from, or penalizing Provider for, discussing treatment options with Members regardless of [MANAGED CARE ORGANIZATION NAME]'s position on the treatment options, or advocating on behalf of members within the utilization review or grievance process established by [MANAGED CARE ORGANIZATION NAME], nor shall it penalize Provider because Provider in good faith reports to state or federal authorities any act or practice by [MANAGED CARE ORGANIZATION NAME] that jeopardizes member health or welfare.
9. **No Incentive to Forego Covered Services.** Nothing in the Agreement shall be construed to offer an inducement to Provider to forego providing medically necessary services to a member or referring a member to such services.
10. **Availability and Confidentiality of Health Records.** Provider shall make health records available as required by law to the appropriate state or federal authorities involved in assessing the quality of care or investigating grievances or complaints of Members, and shall comply with the applicable state and federal laws related to confidentiality of medical or health records.
11. **Credentialing Verification Practices.** [MANAGED CARE ORGANIZATION NAME] completes initial verification of credentials before entering into the Agreement. [MANAGED CARE ORGANIZATION NAME] will also conduct periodic recredentialing of Provider's credentials at least once every three (3) years. The criteria for credentialing and recredentialing policies and procedures are available to Provider upon written request. All information obtained in the credentialing process shall be kept confidential, except that it shall be subject to review and correction of any erroneous information by Provider. Records and documents relating to Provider's credentialing verification process shall be retained by [MANAGED CARE ORGANIZATION NAME] for at least three (3) years.
    Provider shall notify [MANAGED CARE ORGANIZATION NAME] immediately of any changes that would impact Provider’s credentialing status or ongoing availability to members, including the status of Provider's license, current level of professional liability coverage, status of hospital privileges, current DEA registration certificate and specialty board certification status as applicable.

Appendix E

Rule H-2011-02, Independent External Review

A link to this rule can be found at the website below:

www.dfr.vermont.gov/sites/default/files/H_2011_02_adopted_rule.pdf

Appendix F

DFR-Approved Notices of Vermont Appeal Rights

Grandfathered Individual and Group Health Plan Rights Notices			
Attachment	**Type**	**Grievance Levels in Rights Notice**	**For Use With**
A	All-in-One	1st Level Grievance, Voluntary 2nd Level Grievance and Independent External Review	Initial UR Request Determination
B	Level One	Voluntary 2nd Level Grievance and Independent External Review	1st Level Grievance Determination
C	Level Two	Independent External Review	2nd Level Grievance Determination
D	Level One – Unrelated to Denial	Voluntary 2nd Level Grievance	1st Level Grievance Determination Unrelated to Denial
E	Level Two – Unrelated to Denial	Additional Assistance	Voluntary 2nd Level Grievance

Non-Grandfathered Individual and Group Health Plan Rights Notices (Health plans that are newly effective after July 1, 2011 provide only two types of appeal processes: 1st Level Grievance and Independent External Review.)			
Attachment	**Type**	**Grievance Levels in Rights Notice**	**For Use With**
F	All-in-One	1st Level Grievance and Independent External Review	Initial UR Request Determination
G	Level One	Independent External Review	1st Level Grievance Determination
H	Level One – Unrelated to Denial	Additional Assistance	1st Level Grievance Determination Unrelated to Denial

Rights notices are available at the DFR Website at www.dfr.vt.gov

Appendix G

General UM Requirements that Apply to Pharmacy Benefit Management

- 3.1 (B) 6: Training and Inter-rater Reliability Testing
- 3.2 (A): Written Procedures for Making UR Decisions
- 3.2 (B): Timeliness of Pharmacy Benefit UR Decisions
- 3.2 (D) 2-3: Timeframe for Completion and Notification of UR Decisions